Miami-Dade County
Department of Human Services
Child Development Services Bureau

TRANSFER REQUEST

Provider please fax completed form to:
Debbie Outing • 305-514-6166

Early Learning Coalition of Miami-Dade/Monroe

Date _____/ _____/ _____

Parent Name _____ Parent Last 4 Digits of SS# _____ Zip Code _____

CHILD(REN) INFORMATION

Child(ren)'s Name (Last Name, First Name)	Last 4 digits of Child's SS#	D.O.B	INFANT	TODDLER	2- YR OLD	PRE-SCH.	4-YR OLD	5-YR OLD	SCL-	Weekend Care (Mark X)	After School Care		Remaining Full Time at School Break/Hldy	Weekly Parent Fee	
											PT	FT		PT	FT

TRANSFERRED FROM

Name of School _____

Address _____ City _____ Zip _____

Phone (_____) _____ Provider ID & Ext _____

Date Authorization for Care Expires _____/ _____/ _____

I attest that the parent has a zero (0) balance at this early care and educational facility.

_____
Director or Authorized Representative Signature

URGENT: For providers with multiple locations, you must submit the correct transfer request form for each site with the correct site code and address.
****Payment may be impacted for incorrect submissions.***

TRANSFERRED TO

Name of School _____ First Date of Service _____/ _____/ _____ Type of Care: FT ☐ PT ☐ Both ☐

Address _____ City _____ Zip _____ Phone # (_____)_____ Fax # (_____)_____

Provider Signature _____ Provider ID & Ext _____ Date _____/ _____/ _____

I have requested my child(ren) to be transferred to the provider listed on this form. I understand that this request cannot be approved if I have a financial balance with the current provider, and I could risk losing my child care if there is an outstanding balance with any provider receiving school readiness funding.

Parent Signature _____ Date_____/ _____/ _____

Parent Address _____ Zip Code_____ Parent Phone Number (_____)_____